FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037754

Facility Name: The Imperial Grove Pavilion

Address: 1366 West Fullerton (Number) Chicago (City) 60614 (Zip Code)

County: Cook

Telephone Number: (773) 539-2122 **Fax #** (773) 935-0036

IDPA ID Number: 363796886001

Date of Initial License for Current Owners: 01/31/92

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,768	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,768	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	54,913	9,646	6,667	71,226	8
9	SNF/PED					9
10	ICF	6,702	2,662		9,364	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,615	12,308	6,667	80,590	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.79%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 01/31/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 01/01/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 6,667

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	414,606	6,079	744,348	1,165,033		1,165,033	(61,823)	1,103,210			1
2	Food Purchase		47,438		47,438		47,438	(297)	47,141			2
3	Housekeeping	69,173	81,080	287,077	437,330		437,330	12,270	449,600			3
4	Laundry		39,450	189,600	229,050		229,050		229,050			4
5	Heat and Other Utilities			293,053	293,053		293,053	3,928	296,981			5
6	Maintenance	92,027	54,512	171,209	317,748		317,748	4,332	322,080			6
7	Other (specify):*											7
8	**TOTAL General Services**	575,806	228,559	1,685,287	2,489,652		2,489,652	(41,590)	2,448,062			8
	B. Health Care and Programs											
9	Medical Director			37,000	37,000		37,000		37,000			9
10	Nursing and Medical Records	2,855,963	262,574	161,702	3,280,239		3,280,239		3,280,239			10
10a	Therapy	158,853		321,040	479,893		479,893		479,893			10a
11	Activities	103,373	30,457	2,143	135,973		135,973		135,973			11
12	Social Services	46,908		8,558	55,466		55,466		55,466			12
13	Nurse Aide Training			3,040	3,040		3,040		3,040			13
14	Program Transportation			800	800		800		800			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,165,097	293,031	534,283	3,992,411		3,992,411		3,992,411			16
	C. General Administration											
17	Administrative	172,562		180,763	353,325		353,325	(180,763)	172,562			17
18	Directors Fees											18
19	Professional Services			133,252	133,252		133,252	(19,471)	113,781			19
20	Dues, Fees, Subscriptions & Promotions			49,277	49,277		49,277	2,367	51,644			20
21	Clerical & General Office Expenses	581,905	63,325	64,758	709,988		709,988	29,466	739,454			21
22	Employee Benefits & Payroll Taxes			647,150	647,150		647,150	107,823	754,973			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,655	8,655		8,655	779	9,434			24
25	Other Admin. Staff Transportation			15,441	15,441		15,441	(5,708)	9,733			25
26	Insurance-Prop.Liab.Malpractice			110,752	110,752		110,752	739	111,491			26
27	Other (specify):*											27
28	**TOTAL General Administration**	754,467	63,325	1,210,048	2,027,840		2,027,840	(64,768)	1,963,072			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,495,370	584,915	3,429,618	8,509,903		8,509,903	(106,358)	8,403,545			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number The Imperial Grove Pavilion #0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			140,750	140,750		140,750	456,337	597,087			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			235,885	235,885		235,885	1,319,792	1,555,677			32
33	Real Estate Taxes			(1,674)	(1,674)		(1,674)	393,341	391,667			33
34	Rent-Facility & Grounds			1,873,787	1,873,787		1,873,787	(1,873,787)				34
35	Rent-Equipment & Vehicles			6,685	6,685		6,685	2,834	9,519			35
36	Other (specify):*											36
37	TOTAL Ownership			2,255,433	2,255,433		2,255,433	298,517	2,553,950			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	104,211	555,001	34,548	693,760		693,760		693,760			39
40	Barber and Beauty Shops	28,342	530		28,872		28,872		28,872			40
41	Coffee and Gift Shops		554		554		554		554			41
42	Provider Participation Fee			136,152	136,152		136,152		136,152			42
43	Other (specify):* Nonallowable costs			478,729	478,729		478,729	(478,729)				43
44	TOTAL Special Cost Centers	132,553	556,085	649,429	1,338,067		1,338,067	(478,729)	859,338			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,627,923	1,141,000	6,334,480	12,103,403		12,103,403	(286,570)	11,816,833			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(297)	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,908)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,040)	30		9
10	Interest and Other Investment Income	(36,944)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8,760)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,167)	43		18
19	Entertainment				19
20	Contributions	(14,066)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,443)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(231,455)	43		24
25	Fund Raising, Advertising and Promotional	(196,136)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(107,599)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (640,815)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	354,245		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 354,245		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (286,570)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

The Imperial Grove Pavilion

ID# 0037754

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred maintenance cost (net)	$ 850	6	1
2	Disallow patient clothing	(10,237)	43	2
3	Offset wage assignment fees	(163)	21	3
4	Disallow out of state travel	(490)	24	4
5	Miscellaneous income offset	(604)	21	5
6	Personal use of auto income	(360)	25	6
7	Disallow non-patient care auto expense	(5,348)	25	7
8	Nonallowable real estate taxes	(91,115)	33	8
9	Offset cable tv, telephone income	(132)	21	9
10				10
11				11
12				12
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89				89
90	**Total**	(107,599)		90

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Robert Hartman	30.00%	See Attached Schedule 6H		ITEX Mgmt. Co.	Lincolnwood	Management Co.
Barry Carr	10.00%			AK Care	Lincolnwood	Management Co.
Michael Harris	20.00%			Care Path Health	Lincolnwood	
Jack Rajchenbach	20.00%			Network		Management Co.
Bernard Hollander	20.00%			The Claridge, LLC	Lincolnwood	Lessor
				Claridge Ivy, LTD	Lincolnwood	Retirement Comm.
				JLR Management	Lincolnwood	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,873,787	The Claridge, L.L.C.	100.00%	$	$ (1,873,787)	1
2	V	30	Depreciation Building		The Claridge, L.L.C.	100.00%	360,933	360,933	2
3	V	30	Depreciation Equipment		The Claridge, L.L.C.	100.00%	71,839	71,839	3
4	V	32	Interest		The Claridge, L.L.C.	100.00%	1,317,550	1,317,550	4
5	V	32	Amortization of Loan Cost		The Claridge, L.L.C.	100.00%	21,287	21,287	5
6	V	33	Property Taxes		The Claridge, L.L.C.	100.00%	477,319	477,319	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,873,787			$ 2,248,928	$ * 375,141	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	ITEX Management Company & AK Care	70.00%	$ 3,752	$ 3,752	15
16	V	3	Housekeeping		ITEX Management Company & AK Care	70.00%	12,270	12,270	16
17	V	5	Utilities		ITEX Management Company & AK Care	70.00%	3,928	3,928	17
18	V	6	Repairs and Maintenance		ITEX Management Company & AK Care	70.00%	3,482	3,482	18
19	V	17	Management Fees	161,040	ITEX Management Company & AK Care	70.00%		(161,040)	19
20	V	19	Professional Fees		ITEX Management Company & AK Care	70.00%	6,485	6,485	20
21	V	20	Dues, Subscriptions, Licenses		ITEX Management Company & AK Care	70.00%	1,522	1,522	21
22	V	21	Offices Expenses		ITEX Management Company & AK Care	70.00%	29,048	29,048	22
23	V	22	Employee Benefits		ITEX Management Company & AK Care	70.00%	38,745	38,745	23
24	V	24	Education and Seminars		ITEX Management Company & AK Care	70.00%	1,236	1,236	24
25	V	26	Insurance		ITEX Management Company & AK Care	70.00%	739	739	25
26	V	30	Depreciation Expense		ITEX Management Company & AK Care	70.00%	24,605	24,605	26
27	V	32	Interest and Amortization Expense		ITEX Management Company & AK Care	70.00%	17,899	17,899	27
28	V	33	Real Estate Taxes		ITEX Management Company & AK Care	70.00%	7,137	7,137	28
29	V	35	Equipment Rental		ITEX Management Company & AK Care	70.00%	2,834	2,834	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 161,040			$ 153,682	$ * (7,358)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	Management Fees	$ 19,723	Care Path Health Network	70.00%	$	$ (19,723)	15
16	V	19	Professional Fees		Care Path Health Network	70.00%	487	487	16
17	V	20	Dues, Subscriptions, Licenses		Care Path Health Network	70.00%	845	845	17
18	V	21	Office Expenses		Care Path Health Network	70.00%	1,317	1,317	18
19	V	22	Employee Benefit		Care Path Health Network	70.00%	3,503	3,503	19
20	V	24	Education and Seminar		Care Path Health Network	70.00%	33	33	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 19,723			$ 6,185	$ * (13,538)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Barry Carr	Administrative	Exec. Admin	10.00%	**272,279	15	38%	Salary	$ 34,107	L17, C1	1
2	Michael Harris	Vice President	Administrative	20.00%		35	88%	Salary	41,885	L17, C1	2
3	David Hartman	Administrator	Administrator	0.00%	**37727	33.3	83%	Salary	75,374	L17, C1	3
4											4
5											5
6					**see attached schedule 7A						6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 151,366		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX Management Company
Street Address: 6633 North Lincoln Avenue
City / State / Zip Code: Lincolnwood, IL. 60645
Phone Number: (847) 676-2122
Fax Number: (847) 679-4606

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Bed days available	463,722	5	$ 19,169	$	90,768	$ 3,752	1
2	3	Housekeeping	Bed days available	463,722	5	62,684		90,768	12,270	2
3	5	Utilities	Bed days available	463,722	5	20,070		90,768	3,928	3
4	6	Repairs and Maintenance	Bed days available	463,722	5	11,468		90,768	2,245	4
5	6	Scavenger and Exterminating	Bed days available	463,722	5	6,320		90,768	1,237	5
6	19	Accounting Fees	Bed days available	463,722	5	2,323		90,768	455	6
7	19	Data Processing	Bed days available	463,722	5	30,805		90,768	6,030	7
8	19	Legal Fees	Bed days available	463,722	5	0		90,768	0	8
9	20	Classified Advertising	Bed days available	463,722	5	1,038		90,768	203	9
10	20	Dues and Subscriptions	Bed days available	463,722	5	1,308		90,768	256	10
11	20	Employment Recruitment Fees	Bed days available	463,722	5	5,429		90,768	1,063	11
12	21	Bank Services Charges	Bed days available	463,722	5	2,129		90,768	417	12
13	21	Office Supplies	Bed days available	463,722	5	52,456		90,768	10,268	13
14	21	Postage	Bed days available	463,722	5	52,857		90,768	10,346	14
15	21	Telephone	Bed days available	463,722	5	40,667		90,768	7,960	15
16	21	Annual Report	Bed days available	463,722	5	293		90,768	57	16
17	22	Holiday Expense	Bed days available	463,722	5	2,641		90,768	517	17
18	24	Education and Seminars	Bed days available	463,722	5	6,314		90,768	1,236	18
19	26	Insurance	Bed days available	463,722	5	3,777		90,768	739	19
20	30	Depreciation	Bed days available	463,722	5	125,704		90,768	24,605	20
21	32	Amortization Loan Costs	Bed days available	463,722	5	1,164		90,768	228	21
22	32	Interest Expense	Bed days available	463,722	5	90,279		90,768	17,671	22
23	33	Real Estate Taxes	Bed days available	463,722	5	36,464		90,768	7,137	23
24	35	Equipment Rental	Bed days available	463,722	5	14,476		90,768	2,834	24
25	TOTALS					$ 589,835	$		$ 115,454	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX Management Company
Street Address: 6633 North Lincoln Avenue
City / State / Zip Code: Lincolnwood, IL. 60645
Phone Number: (847) 676-2122
Fax Number: (847) 679-4606

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Health Insurance	Payroll	735,869	5	$ 102,879	$	176,960	$ 24,740	1
2	22	Payroll Taxes	Payroll	735,869	5	54,551		176,960	13,118	2
3	22	Workers' Compensation Ins.	Payroll	735,869	5	1,538		176,960	370	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 158,968	$		$ 38,228	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Path Health Network
Street Address: 6633 North Lincoln Avenue
City / State / Zip Code: Lincolnwood, IL. 60645
Phone Number: (847) 676-2122
Fax Number: (847) 679-4606

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Accounting Fees	Fee Income	608,174	12	$ 1,295	$	44,553	$ 95	1
2	19	Data Processing	Fee Income	608,174	12	5,022		44,553	368	2
3	19	Legal Fees	Fee Income	608,174	12	329		44,553	24	3
4	20	License	Fee Income	608,174	12	290		44,553	21	4
5	20	Dues and Subscriptions	Fee Income	608,174	12	1,460		44,553	107	5
6	20	Classified Advertising	Fee Income	608,174	12	9,785		44,553	717	6
7	21	Office Supplies	Fee Income	608,174	12	6,226		44,553	456	7
8	21	Outside Office Help	Fee Income	608,174	12	1,457		44,553	107	8
9	21	Postage	Fee Income	608,174	12	293		44,553	21	9
10	21	Telephone	Fee Income	608,174	12	10,008		44,553	733	10
11	22	Employee Health Welfare	Fee Income	608,174	12	21,317		44,553	1,562	11
12	22	Payroll Taxes	Fee Income	608,174	12	26,493		44,553	1,941	12
13	24	Education and Seminars	Fee Income	608,174	12	449		44,553	33	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 84,424	$		$ 6,185	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lincoln National Life Insurance		x	Mortgage ***	$80,255.00	09/1/89	$ 6,254,345	$ 5,874,485	09/01/07	0.1050	$ 624,297	1
2	Lincoln National Life Insurance		x	Mortgage ***	$13,595.00	09/1/89	1,036,602	975,735	09/01/07	0.1088	107,357	2
3	Lincoln National Life Insurance		x	Mortgage ***	$6,538.00	11/1/92	509,189	483,702	11/01/07	0.1094	53,444	3
4	LaSalle National Bank		x	Mortgage	$64,321.00	10/1/98	7,345,625	7,112,135	10/01/23	0.0744	532,452	4
5	Hill Rom		x	Purchase of Equipment	$890.00	3/16/00	21,357	12,459	03/15/02	0.1000	1,327	5
	Working Capital											
6	LaSalle National Bank	x		Line of Credit	Interest only	12/21/99	2,500,000	0	12/31/00	P+.0050	114,014	6
7	LaSalle National Bank		x	Line of Credit	Interest only	12/14/00	3,000,000	3,000,000	04/30/01	P+.0050	118,339	7
8	Nursing Home Risk Mgmt		x	Workers' Comp	$5,168.00	12/31/99	55,000	1,852	12/31/00	0.0700	1,852	8
9	TOTAL Facility Related				$170,767.00		$ 20,722,118	$ 17,460,368			$ 1,553,082	9
	B. Non-Facility Related*											
10	From Page 9A						557,202	555,665			353	10
11								Interest income offset			(36,944)	11
12	*** These loans were assumed by The Claridge L.L.C. as of 10/1/98 under the same terms as the original mortgage holder							Amortization of mortgage cost			21,287	12
13								Allocated from management company			17,899	13
14	TOTAL Non-Facility Related						$ 557,202	$ 555,665			$ 2,595	14
15	TOTALS (line 9+line14)						$ 21,279,320	$ 18,016,033			$ 1,555,677	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$	508,178	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$	480,730	2
3. Under or (over) accrual (line 2 minus line 1).		$	(27,448)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	**	$	504,767	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	4,932	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Allocated from Mgmt Co. Refund from County Adjust taxes paid to 67%		7,137 (1,122) (96,599)	
TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	391,667	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	436,060	8
1996	451,410	9
1997	475,537	10
1998	483,979	11
1999	480,730	12

** 1999 real Estate Tax Bill	480,730	* 1999 Total Real Estate Tax Bill	572,298	
Estimated Increase	1.05	Imperial portion for financial stmt	480,730	84%
2000 Accrual	504,767	Imperial portion for cost report	384,131	67%
		Adjustment	(96,599)	

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13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 91,703 B. General Construction Type: Exterior Brick Frame Reinforced Concrete Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Claridge Lincoln Park, Ltd; Reirement apartments rental; 119 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1998	$ 40,000	1
2					2
3	TOTALS			$ 40,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	248		1998	1984	$ 14,437,336	$	40	$ 360,933	$ 360,933	$ 812,099	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Leasehold Improvements			1992	60,378	3,032	20	3,032		25,771	9
10	Leasehold Improvements			1993	59,308	2,965	20	2,965		22,238	10
11	Leasehold Improvements			1994	10,638	532	20	532		3,458	11
12	Leasehold Improvements			1995	43,191	2,160	20	2,160		11,880	12
13	Furnace			1996	1,843	92	20	92		414	13
14	Door Locks			1996	2,357	118	20	118		531	14
15	Windows			1996	8,365	418	20	418		1,881	15
16	Electrical Wiring			1996	4,880	244	20	244		1,098	16
17	Fence			1996	1,067	53	20	53		239	17
18	Gutters			1996	1,574	79	20	79		355	18
19	Brick Wall			1996	2,560	128	20	128		576	19
20	Ceiling Lights			1996	5,501	274	20	274		1,235	20
21	Nurse Station			1996	2,500	124	20	124		559	21
22	Countertops			1996	2,610	131	20	131		588	22
23	Convection Oven			1996	7,515	376	20	376		1,691	23
24	Boiler			1996	2,927	146	20	146		657	24
25	Fence			1997	1,050	53	20	53		185	25
26	Electrical Improvements			1997	1,671	84	20	84		294	26
27	Nurse Call Station			1997	3,501	175	20	175		613	27
28	Public Address System			1997	1,360	68	20	68		238	28
29	Brick Wall			1997	5,110	256	20	256		896	29
30	Floor Tile			1997	21,705	1,085	20	1,085		3,798	30
31	Fire Doors			1997	4,096	205	20	205		717	31
32	Carpeting			1997	3,243	162	20	162		567	32
33	Inspection Improvements			1997	9,884	494	20	494		1,729	33
34	Door Restrictors			1997	8,475	424	20	424		1,484	34
35	Fire Alarm			1997	2,082	103	20	103		362	35
36	TOTAL (lines 4 thru 35)				$ 14,716,727	$ 13,981		$ 374,914	$ 360,933	$ 896,153	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6			1993	1993	313,974		35	8,971	8,971	68,027	6
7											7
8											8
	Improvement Type**										
9	Sheet Metal			1998	11,981	599	20	599		1,498	9
10	Lighting			1998	7,156	358	20	358		895	10
11	Screens			1998	2,704	135	20	135		338	11
12	Piping			1998	4,145	207	20	207		518	12
13	Fire Alarms & Fire Proofing			1998	12,534	627	20	627		1,567	13
14	Tile			1998	967	49	20	49		122	14
15	Driveway			1998	7,342	367	20	367		918	15
16	Tuckpointing			1998	39,242	1,962	20	1,962		4,904	16
17	Ground Fuel Tank			1999	17,985	899	20	899		1,349	17
18	Carpet			1999	28,114	1,406	20	1,406		2,109	18
19	Wallcovering			1999	36,585	1,830	20	1,830		2,744	19
20	Floor in Dinning Room			1999	9,850	493	20	493		739	20
21	Signs			1999	1,765	88	20	88		132	21
22	Electrical Work			1999	20,508	1,025	20	1,025		1,538	22
23	Brick & Masonry Work			1999	12,345	617	20	617		925	23
24	Gas Line Improvements			1999	1,633	82	20	82		123	24
25	Alarm System			1999	1,388	69	20	69		104	25
26	Wallcovering			2000	21,554	539	20	539		539	26
27	Flooring			2000	13,293	332	20	332		332	27
28	Carpet			2000	8,284	207	20	207		207	28
29	Over Bed Lights			2000	4,593	115	20	115		115	29
30	Compactor			2000	6,800	170	20	170		170	30
31	Paging System			2000	9,909	248	20	248		248	31
32	CCTV System			2000	5,456	136	20	136		136	32
33	Wander Guard System			2000	18,540	464	20	464		464	33
34	Handrails, Kickplates, Wallbases			2000	6,038	151	20	151		151	34
35	Fuel Tank Project			2000	1,444	36	20	36		36	35
36	TOTAL (lines 4 thru 35)				$ 626,129	$ 13,211		$ 22,182	$ 8,971	$ 90,948	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FirstQ System			2000	1,378	34	20	34		34	9
10	Chain Link Fence			2000	745	19	20	19		19	10
11	Alarm System			2000	5,051	126	20	126		126	11
12	Service P.A. System			2000	1,924	48	20	48		48	12
13	Remodel 13 Bedrooms			2000	18,112	453	20	453		453	13
14	Repair Elevator			2000	990	25	20	25		25	14
15	Remodel Smoking Room			2000	23,565	589	20	589		589	15
16	Remodel Old Smoking Room to Library			2000	4,690	117	20	117		117	16
17	Remodel 1st Floor			2000	10,540	264	20	264		264	17
18	Remodel 6th Floor Dining Room			2000	4,970	124	20	124		124	18
19	Remodel 3rd Floor Dining Room			2000	959	24	20	24		24	19
20	Call Station			2000	4,475	112	20	112		112	20
21	Landscaping			2000	2,785		n/a				21
22											22
23											23
24	Allocated from Management Company			1993	39,507		20	1,976	1,976	15,222	24
25	Allocated from Management Company			1994	21,220		20	1,061	1,061	6,665	25
26	Allocated from Management Company			1995	3,616		20	181	181	940	26
27	Allocated from Management Company			1996	205		20	10	10	51	27
28	Allocated from Management Company			1997	6,101		20	305	305	1,068	28
29	Allocated from Management Company			1999	677		20	34	34	68	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 151,510	$ 1,935		$ 5,502	$ 3,567	$ 25,949	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,693,832	$ 97,581	$ 169,420	$ 71,839	10	$ 679,860	37
38	Current Year Purchases	199,040	9,952	9,952		10	9,952	38
39	Fully Depreciated Assets							39
40	Allocated from Mgmt Co. & Related Party	110,588		11,027	11,027		52,172	40
41	TOTALS	$ 2,003,460	$ 107,533	$ 190,399	$ 82,866		$ 741,984	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	1994 Ford Van	1994	$ 30,750	$	$	$	5 yrs	$ 30,750	42
43	Patient Care	1998 Ford Van	1999	20,449	4,090	4,090		5 yrs	6,135	43
44										44
45										45
46	TOTALS			$ 51,199	$ 4,090	$ 4,090	$		$ 36,885	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 17,589,025	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 140,750	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 597,087	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 456,337	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,791,919	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 9,519 Description: Medical Eq. $1,567; Copier $4,632; Postage Meter $115; Furniture $371; Allocated from Mgmt Co $ 2,834
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 2,840	$	$ 2,840
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		200		200
9	TOTALS	$	$ 3,040	$	$ 3,040
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,040			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ n/a

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10a, C3	hrs	$	7,402	$ 111,625	$	7,402	$ 111,625	1
2	Licensed Speech and Language Development Therapist	L 10a, C3	hrs		1,449	22,867		1,449	22,867	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C1,3	hrs		10,827	171,163		10,827	171,163	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescrpts				442,015		442,015	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	L39, C1,2	5359	104,211			15,124	5,359	119,335	12
13	Other (specify): See attached Schedule 16A			88,713		34,548	97,862		221,123	13
14	TOTAL			$ 192,924	19,678	$ 340,203	$ 555,001	25,037	$ 1,088,128	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion **#** 0037754 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 77,439	$ 77,439	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 275,000)	4,328,519	4,328,519	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	88,979	88,979	6
7	Other Prepaid Expenses	398,703	398,703	7
8	Accounts Receivable (owners or related parties)	340,146	1,088,352	8
9	Other(specify): See Schedule 17A	618,954	618,954	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,852,740	$ 6,600,946	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	2,785	42,785	13
14	Buildings, at Historical Cost		14,822,636	14
15	Leasehold Improvements, at Historical Cost	669,204	668,945	15
16	Equipment, at Historical Cost	1,225,676	2,054,659	16
17	Accumulated Depreciation (book methods)	(673,969)	(1,791,919)	17
18	Deferred Charges		1,275	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs		248,475	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,223,696	$ 16,046,856	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,076,436	$ 22,647,802	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 363,549	$ 363,549	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	62,147	62,147	28
29	Short-Term Notes Payable	3,014,257	3,014,257	29
30	Accrued Salaries Payable	312,346	312,346	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,595	35,595	31
32	Accrued Real Estate Taxes(Sch.IX-B)		504,767	32
33	Accrued Interest Payable	22,720	131,470	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,235,134	1,235,134	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,045,748	$ 5,659,265	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	555,719	15,001,776	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 555,719	$ 15,001,776	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,601,467	$ 20,661,041	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,474,969	$ 1,986,761	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,076,436	$ 22,647,802	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,885,028	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,885,028	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(410,059)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (410,059)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,474,969	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,340,483	1
2	Discounts and Allowances for all Levels	(650,032)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,690,451	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,143,876	6
7	Oxygen	26,742	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,170,618	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	27,886	13
14	Non-Patient Meals	297	14
15	Telephone, Television and Radio	132	15
16	Rental of Facility Space		16
17	Sale of Drugs	492,382	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	94,782	19
20	Radiology and X-Ray		20
21	Other Medical Services	165,469	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 780,948	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	36,944	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 36,944	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19E	14,383	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,383	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,693,344	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,489,652	31
32	Health Care	3,992,411	32
33	General Administration	2,027,840	33
	B. Capital Expense		
34	Ownership	2,255,433	34
	C. Ancillary Expense		
35	Special Cost Centers	1,201,915	35
36	Provider Participation Fee	136,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,103,403	40
41	**Income before Income Taxes (line 30 minus line 40)****	(410,059)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (410,059)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility files a Cash Basis tax return**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,024	1,039	$ 29,624	$ 28.51	1
2	Assistant Director of Nursing	6,864	7,270	193,975	26.68	2
3	Registered Nurses	34,826	37,177	745,585	20.06	3
4	Licensed Practical Nurses	47,300	49,469	695,059	14.05	4
5	Nurse Aides & Orderlies	133,127	140,505	1,145,963	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,861	7,416	139,721	18.84	7
8	Rehab/Therapy Aides	6,778	7,678	70,140	9.14	8
9	Activity Director	1,502	1,611	18,805	11.67	9
10	Activity Assistants	12,162	12,782	84,568	6.62	10
11	Social Service Workers	2,576	2,723	46,908	17.23	11
12	Dietician					12
13	Food Service Supervisor	1,614	1,859	24,600	13.23	13
14	Head Cook	13,298	14,438	154,467	10.70	14
15	Cook Helpers/Assistants	36,388	38,272	235,539	6.15	15
16	Dishwashers					16
17	Maintenance Workers	7,931	8,306	92,027	11.08	17
18	Housekeepers	10,403	10,980	69,173	6.30	18
19	Laundry					19
20	Administrator	1,923	2,165	96,570	44.61	20
21	Assistant Administrator					21
22	Other Administrative	2,496	2,560	75,992	29.68	22
23	Office Manager					23
24	Clerical	23,947	25,504	581,905	22.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(spe Care Plan Coord	4,339	4,554	98,960	21.73	32
33	Other(specify) Beautician	1,926	2,227	28,342	12.73	33
34	TOTAL (lines 1 - 33)	357,285	378,535	$ 4,627,923 *	$ 12.23	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,929	L1,C3	35
36	Medical Director	Monthly	37,000	L9,C3	36
37	Medical Records Consultant	77	3,979	L10,C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,500	L10,C3	39
40	Physical Therapy Consultant	213	10,660	L10A,C3	40
41	Occupational Therapy Consultant	83	4,150	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	12	575	L10A,C3	43
44	Activity Consultant	47	2,143	L11,C3	44
45	Social Service Consultant	92	4,958	L12,C3	45
46	Other(specify)				46
47	Religious Services	Monthly	3,600	L12,C3	47
48					48
49	TOTAL (lines 35 - 48)	524	$ 84,494		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	840	$ 38,540	L10,C3	50
51	Licensed Practical Nurses	3,079	87,820	L10,C3	51
52	Nurse Aides	1,625	29,863	L10,C3	52
53	TOTAL (lines 50 - 52)	5,544	$ 156,223		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mike Toral	Administrator	0.00%	$ 21,196
David Hartman	Administrator	0.00%	75,374
Michael Harris	Administrative	20.00%	41,885
Barry Carr	Administrative	10.00%	34,107
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 172,562

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 180,763
TOTAL (agree to Schedule V, line 17, col. 3)	$ 180,763
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc	Unemployment Consulting	$ 1,427
Power Software Development	Computer Consulting	10,331
Extended Care Com	Computer Consulting	4,485
JCAHO	Facility Consulting	4,195
Susan Fox	Accounting	14,940
American Express Tax & Business	Accounting	17,428
Frost, Ruttenberg & Rothblatt, P.C.	Accounting	8,203
Commitment Consulting	Accounting	2,900
Altschuler, Melvoin and Glasser LLP	Accounting	25,600
Sachnoff & Weaver, Ltd.	Legal	8,633
Segal & Segal	Legal	16,704
See Attached Schedule 21 A		18,406
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 133,252

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,381
Unemployment Compensation Insurance	55,837
FICA Taxes	350,240
Employee Health Insurance	168,709
Employee Meals	65,575
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	8,426
Miscellaneous Employee Benefits	13,238
Tuition Reimbursement	11,369
Uniforms	8,530
Christmas Expenses	10,668
TOTAL (agree to Schedule V, line 22, col.8)	$ 754,973

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	20,558
Health Care Worker Background Check	
(Indicate # of checks performed 218)	3,098
Illinois Council on Long-Term Care	9,220
JCAHO	2,986
Various Dues, Subcriptions, & Manuals	5,367
Various Inspections	5,017
Various Licenses & Permits	2,631
Allocated from Management Company	2,367
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 51,644

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	661
Seminar Expense	7,504
Allocated from Management Company	1,269
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,434

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Repairs to Chiller	02/28/99	$ 2,550	3	$	$	$ 425	$ 850	$ 850	$ 425	$	$	$
2													
3													
4													
5													
6													
7													
8													
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20	TOTALS		$ 2,550		$	$	$ 425	$ 850	$ 850	$ 425	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Imperial Grove Pavilion # 0037754 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on Long-Term Care $9220**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,768** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **136,152**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N0** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **65,575** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.